## Using Health Literacy Tools to Meet PCMH Standards

As part of being patient-centered, a medical home needs to make it easy for people to navigate, understand, and use information and services to take care of their health. This is, in fact, the definition of a health literate health care organization (Brach et al. 2012). Many patients, however, find health information and health care systems confusing.

Addressing health literacy in your practice can help you engage your patients and qualify for certification or recognition as a patient-centered medical home (PCMH) or the equivalent (e.g., Primary Care Medical Home, Health Care Home). The AHRQ Health Literacy Universal Precautions Toolkit can help practices reduce the complexity of health care, increase patient understanding of health information, and enhance support for patients of all literacy levels. This crosswalk identifies tools that are relevant to specific PCMH certification and recognition standards (as of January 2015) of the following three organizations:

- The National Committee for Quality Assurance (NCQA)
- The Joint Commission
- URAC

There are two parts of the crosswalk. The first part gives you an at-a-glance table that shows which health literacy tools are applicable to each standard. The second part spells out each standard and gives the full name of helpful health literacy tools.

Implementation of health literacy tools may contribute to your efforts to attain PCMH certification or recognition. However, we cannot guarantee that implementation of a given tool will result in a practice successfully meeting a given certification standard. It is also important to note that standards are updated frequently. Check the most recent PCMH standards to ensure you have the latest guidelines.

| PCMH Standard/Element | AHRQ Health Literacy Universal Precautions Tool | | | | | | | | | | | | | | | | | | | | |
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| **NCQA** | | | | | | | | | | | | | | | | | | | | | |
| PCMH 1: Patient-Centered Access | | | | | | | | | | | | | | | | | | | | | |
| Element B: 24/7 Access to Clinical Advice #2 | | | | | | | X | | | | | | | | | | | | | | |
| Element C: Electronic Access #3 | | | | | | | | | | | X | | | | | | | | | | |
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| PCMH 2: Team-Based Care | | | | | | | | | | | | | | | | | | | | | |
| Element A: Continuity #1,3,4 | | | | | | | | | | | X | | X | | | | | | | | |
| Element B: Medical Home Responsibilities #1-8 | | | | | | | | | | | X | | X | | | | | | X | | |
| Element C: Culturally and Linguistically Appropriate Services #1-4 | | | | | | | | | X | X | X | | | | | | | | | | |
| Element D: The Practice Team #5,6,9, 10 | X | | X | X | X | X | | | | | X | X | | X | X | X | X | X | X | X | X |
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| PCMH 3: Population Health Management | | | | | | | | | | | | | | | | | | | | | |
| Element C: Comprehensive Health Assessment #1-10 | | | | X | | | | | | X | X | | | | | | | | | | |
| Element D: Use Data for Population Management #1-5 | | | | | | X | | | | | X | | | | | | | | | | |
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| PCMH 4: Care Management and Support | | | | | | | | | | | | | | | | | | | | | |
| Element B: Care Planning and Self-Care Support #1-5 | | | | X | X | X | | | | | X | X | | X | X | | | X | X | X | X |
| Element C: Medication Management #3-6 | | | | X | X | | | X | | | X | X | | X | | X | | | X | | |
| Element E: Provide Referrals to Community Resources #2-7 | | | | X | | X | | | | | X | X | | X | | | | X | X | X | X |
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| PCMH 5: Care Coordination and Care Transitions | | | | | | | | | | | | | | | | | | | | | |
| Element A: Test Tracking and | | | | X | X | X | | | | | X | | | X | | | | | | | X |

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| Followup #1,2,5 | | | | | | | | | | | | | | | | | | | | | |
| Element B: Referral Tracking and Followup #1-10 | | | | X | | X | | | | | | | | | | | | | | | X |
| Element C: Coordinate Care Transitions #4 | | | | X | X | X | | | | | | | | | | | | | | | |
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| PCMH 6: Performance Measurement and Quality Improvement | | | | | | | | | | | | | | | | | | | | | |
| Element C: Measure Patient/Family Experience #3,4 | | | | | | | | | | | | | | | | | X | | | | |
| Element D: Implement Continuous Quality Improvement #5-7 | X | X | | | | | | | | | | | | | | | | | | | |
| Element E: Demonstrate Continuous Quality Improvement #1 | | X | | | | | | | | | | | | | | | | | | | |
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| **Joint Commission** | | | | | | | | | | | | | | | | | | | | | |
| LD.04.04.01: Performance Improvement | | | | | | | | | | | | | | | | | | | | | |
| EP 5. Ongoing performance improvement | | X | | | | | | | | | | | | | | | | | | | |
| EP 24. Leaders involve patients in performance improvement activities | X | | | | | | | | | | | | | | | | | | | | |
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| PC.01.03.01: Plan Patient's Care | | | | | | | | | | | | | | | | | | | | | |
| EP 44. Patient self-management goals are identified, agreed upon with the patient, and incorporated into the patient's treatment plan | | | | X | | | | | | | | | | X | X | | | | | | |
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| PC.02.01.21: Effective Communication with Patients | | | | | | | | | | | | | | | | | | | | | |
| EP 1. The primary care clinician and | | | | | | | | | X | | X | | | | | | | | | X | |

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| the interdisciplinary team identify the patient's oral and written communication needs, including the patient's preferred language for discussing health care. | | | | | | | | | | | | | | | | | | | | | |
| EP 2. The primary care clinician and the interdisciplinary team communicate with the patient during the provision of care, treatment, or services in a manner that meets the patient's oral and written communication needs | | | | X | | | X | | X | | X | | | X | | | | | | | |
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| PC.02.02.01: Coordination Based on Patient's Needs | | | | | | | | | | | | | | | | | | | | | |
| EP 24. The interdisciplinary team identifies the patient's health literacy needs. Note: Typically this is an interactive process. For example, patients may be asked to demonstrate their understanding of information provided by explaining it in their own words. | | | | X | X | | | | | | | | | X | | | | | | X | |
| EP 25. The primary care clinician and the interdisciplinary team incorporate the patient's health literacy needs into the patient's education | | | | X | | | | X | | | | X | | | | | | | | | |
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| PC.02.03.01: Patient Education | | | | | | | | | | | | | | | | | | | | | |
| EP 28. The primary care clinician and the interdisciplinary team educate the patient on self-management tools and techniques based on the patient's individual needs. | | | | X | X | X | | | | | | X | | X | X | X | | | X | | |

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| PC.02.04.03: Accountability | | | | | | | | | | | | | | | | | | | | | |
| EP 1. The organization manages transitions in care and provides or facilitates patient access to care, treatment, or services. | | | | | | X | | | | | | | | | | | | X | | X | X |
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| PC.02.04.05: Continuous, Comprehensive, and Coordinated Care | | | | | | | | | | | | | | | | | | | | | |
| EP 2. Members of the interdisciplinary team provide comprehensive and coordinated care, treatment, or services and maintain the continuity of care. Note: The provision of care may include making internal and external referrals | | | | | | X | | | | | | | | | | | | X | | X | X |
| EP 6. When a patient is referred to an external organization, the interdisciplinary team reviews and tracks the care provided to the patient | | | | | | X | | | | | | | | | | | | X | | X | X |
| EP 13. The interdisciplinary team actively participates in performance improvement activities | X | X | | | | | | | | | | | | | | | | | | | |
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| PI.01.01.01: Data Collection to Monitor Performance | | | | | | | | | | | | | | | | | | | | | |
| EP 42. The organization also collects data on the following: patient experience and satisfaction related to access to care, treatment, or services, and communication | | | | | | | | | | | | | | | | | X | | | | |
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| RC.02.01.01: Clinical Record | | | | | | | | | | | | | | | | | | | | | |
| EP 28. The clinical record contains the patient's race and ethnicity. | | | | | | | | | | X | | | | | | | | | | | |
| EP 29. The clinical record includes the patient's self-management goals and the patient's progress toward achieving those goals | | | | | | | | | | | | | | | X | | | | | | |
| EP 30. The clinical record contains the patient's communication needs, including preferred language for discussing health care | | | | | | | | | X | | | | | | | | | | | | |
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| RI.01.01.03: Respect Patient's Right to Receive Information in a Manner He or She Understands | | | | | | | | | | | | | | | | | | | | | |
| EP 2. The organization provides interpreting and translation services, as necessary | | | | | | | | | X | | X | | | | | | | | | | |
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| **URAC** | | | | | | | | | | | | | | | | | | | | | |
| Core Quality Care Management | | | | | | | | | | | | | | | | | | | | | |
| MH 1 Staff Orientation and Training Requirements Documentation | X | | X | X | X | X | | | X | X | | | X | X | X | | | | | | |
| MH 2 Effective Practice Workflow | X | | | X | | X | | X | | | | | | | | | | X | X | X | X |
| MH 3 Patient Empowerment and Engagement | | | | X | X | | | | X | X | X | X | | X | X | | | | | | |
| MH 4 Health Literacy | | X | X | X | X | X | X | | X | X | X | X | X | X | X | X | | X | X | X | X |
| MH 5 Patient Rights and Responsibilities | | | | X | X | | | | | | X | | | X | | | | | | | |
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| Patient Centered Operations Management | | | | | | | | | | | | | | | | | | | | | |
| MH 6 Registry – Patient Information and Implementation | | | | | | X | | | | | | | | | | | | | | | |

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| Access and Communications | | | | | | | | | | | | | | | | | | | | | |
| MH7 Patient Access to Services and Information | | | | | | | X | | | | X | | | | | | | | | | X |
| MH 8 Enhancing Patient Access to Services | | | | | | | | | | | X | | | | | | | | | | |
| MH 9 Comprehensive Services and Resources | | | | | | | | | | | | | | | | | X | X | X | X | |
| MH 10 Community Resource Referrals | | | | | | | | | | | | | | | | | | X | | X | X |
| MH 11 Tracking and Followup on Community Resource Referrals | | | | | X | | | | | | | | | | | | | X | | X | X |
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| Testing and Referrals | | | | | | | | | | | | | | | | | | | | | |
| MH 12 Documented Process for Managing Test Results | | | | | | X | | | | | X | X | | | | | | | | | X |
| MH 13 Referral Process | | | | | | | | | | | | | | | | | | X | | | X |
| MH 14 Tracking and Followup on Clinical Referrals | | | | | | X | | | | | | | | | | | | | | | X |
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| Care Management and Coordination | | | | | | | | | | | | | | | | | | | | | |
| MH 15 Promoting Wellness and Comprehensive Health Risk Assessment | | | | X | X | X | | | | | X | X | | X | | | | X | | | |
| MH 16 Wellness Information and Materials | | | | | | | | | | | X | X | | | | | | X | | | |
| MH 17 Patient Reminders | | | | X | | X | | | | | X | | | | X | | | | | | |
| MH 18 Ongoing Care Management Protocols - All Patients | | | | X | X | X | | | | | X | X | | X | X | | | | | | X |
| MH 19 Informed Decision Making with Patients | | | | X | X | | | | | | X | X | | X | | | | | | | |
| MH 20 Medication Review and Reconciliation | | | | X | X | | | X | | | | | | X | | X | | | X | | |
| MH 21 Coordination of Care | | | | | | | | | | | | | | | | | | | | | X |
| MH 22 Coordinating Care | | | | X | X | | | | | | X | | | X | | | | | | | X |

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| Transitions and Written Plans | | | | | | | | | | | | | | | | | | | | | |
| MH 23 Appropriate Use of Clinical Guidelines | | | | | | X | | | | | | | | | | | | X | | X | X |
| MH 24 Health Record Information Exchange and Alerts | | | | | | X | | | | | | | | | | | | X | | X | X |
| MH 25 Chronic Condition - Care Management | | | | | | X | | | | | | | | | | | | X | | X | X |
| MH 26 Self-Management of Chronic Conditions | | | | X | X | X | | | | | X | X | | X | X | X | | | | | |
| MH 27 Chronic Condition - Appointments | | | | | | X | | | | | X | | | | | | | | | | |
| MH 28 Chronic Condition - Followup | | | | | | X | | | | | | | | | | | | | | | |
| MH 29 Self-Management Support and Assessment Capabilities | | | | X | X | X | | | | | X | X | | X | X | X | | | | | |
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| Electronic Capabilities | | | | | | | | | | | | | | | | | | | | | |
| MH 31 Basic Electronic Health Record | | | | | | | | | | | X | | | | | | | | | | |
| MH 32 Advanced Electronic Health Record | | | | | | | | | | | | X | | | | | | | | | |
| MH 33 Electronic Communications Portal | | | | X | | X | | | | | X | | | | | | | | | | |
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| Quality Performance Reporting and Improvement | | | | | | | | | | | | | | | | | | | | | |
| MH 36 Performance Reporting and Validation | | | | | | | | | | | | | | | | | | | | | X |
| MH 39 Performance Improvement | | X | | | | | | | | | | | | | | | X | | | | |

| NCQA PCMH Standard | AHRQ Health Literacy Universal Precautions Tool |
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| **PCMH 1: Patient-Centered Access** | |
| **Element B: 24/7 Access to Clinical Advice**<br><br>2. Providing timely clinical advice by telephone | Tool 7: Improve Telephone Access |
| **Element C: Electronic Access**<br><br>3. Clinical summaries are provided within 1 business day for more than 50 percent of office visits | Tool 11: Assess, Select, and Create Easy-to-Understand Materials |
| **PCMH 2: Team-Based Care** | |
| **Element A: Continuity**<br><br>1. Assisting patients/families to select a personal clinician and documenting the selection in practice records<br><br>3. Having a process to orient new patients to the practice<br><br>4. Collaborating with the patient/family to develop/implement a written care plan for transitioning from pediatric care to adult care | Tool 11: Assess, Select, and Create Easy-to-Understand Materials<br><br>Tool 13: Welcome Patients: Helpful Attitude, Signs, and More |
| **Element B: Medical Home Responsibilities**<br><br>The practice has a process for informing patients/families about the role of the medical home and gives patients/families materials that contain the following information: | Tool 11: Assess, Select, and Create Easy-to-Understand Materials<br><br>Tool 13: Welcome Patients: Helpful Attitude, Signs, and More<br><br>Tool 19: Direct Patients to Medicine Resources |

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| 1. The practice is responsible for coordinating patient care across multiple settings<br><br>2. Instructions for obtaining care and clinical advice during office hours and when the office is closed<br>3. The practice functions most effectively as a medical home if patients provide a complete medical history and information about care obtained outside the practice<br><br>4. The care team provides access to evidence-based care, patient/family education and self-management support<br><br>5. The scope of services available within the practice including how behavioral health needs are addressed<br><br>6. The practice provides equal access to all of their patients regardless of source of payment<br><br>7. The practice gives uninsured patients information about obtaining coverage<br><br>8. Instructions on transferring records to the practice, including a point of contact at the practice | |
| **Element C: Culturally and Linguistically Appropriate Services**<br><br>1. Assessing the diversity of its population<br><br>2, Assesing the language needs of its population<br><br>3. Providing interpretation or bilingual services to meet the language needs of its population | Tool 9: Address Language Differences<br><br>Tool 10: Consider Culture, Customs, and Beliefs<br><br>Tool 11: Assess, Select, and Create Easy-to-Understand Materials |

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| 4, Providing printed materials in the languages of its population | |
| **Element D: The Practice Team**<br><br>5. Training and assigning members of the care team to coordinate care for individual patients<br><br>6. Training and assigning members of the care team to support patients/families/caregivers in self-management, self-efficacy and behavior change<br><br>9. Involving care team staff in the practice's performance evaluation and quality improvement activities.<br><br>10. Involving patients/families/caregivers in quality improvement activities or on the practice's advisory council | Tool 1: Form a Team<br><br>Tool 3: Raise Awareness<br><br>Tool 4: Communicate Clearly<br><br>Tool 5: Use the Teach-Back Method<br><br>Tool 6: Follow Up With Patients<br><br>Tool 11: Assess, Select, and Create Easy-to-Understand Materials<br><br>Tool 12: Use Health Education Material Effectively<br><br>Tool 14: Encourage Questions<br><br>Tool 15: Make Action Plans<br><br>Tool 16: Help Patients Remember How and When to Take Their Medicine<br><br>Tool 17: Get Patient Feedback (includes CAHPS® Item Set for Addressing Health Literacy and qualitative methods)<br><br>Tool 18: Link Patients to Non-Medical Support<br><br>Tool 19: Direct Patients to Medicine Resources<br><br>Tool 20: Connect Patients with Literacy and Math Resources |

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| | Tool 21: Make Referrals Easy |
| **PCMH 3: Population Health Management** | |
| **Element C: Comprehensive Health Assessment**<br>To understand the health risks and information needs of patients/ families, the practice collects and regularly updates a comprehensive health assessment that includes:<br><br>1. Age- and gender appropriate immunizations and screenings<br><br>2. Family/social//cultural characteristics.<br><br>3. Communication needs<br><br>4. Medical history of patient and family<br><br>5. Advance care planning (NA for pediatric practices)<br><br>6. Behaviors affecting health<br><br>7. Mental health/substance use history of patient and family<br><br>8. Developmental screening using a standardized tool (NA for practices with no pediatric patients)<br><br>9. Depression screening for adults and adolescents using a standardized tool<br><br>10. Assessment of health literacy | Tool 4: Communicate Clearly<br><br>Tool 10: Consider Culture, Customs, and Beliefs<br><br>Tool 11: Assess, Select, and Create Easy-to-Understand Materials (includes examples of adult and child health history and visit update forms) |
| **Element D: Use Data for Population Management**<br>At least annually the practice proactively identifies populations of patients and reminds them, or their families/caregivers, of | Tool 6: Follow Up With Patients<br><br>Tool 11: Assess, Select, and Create Easy-to-Understand Materials |

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| needed care based on patient information, clinical data, health assessments and evidence-based guidelines including<br><br>1. At least two different preventive care services<br><br>2. At least two different immunizations<br><br>3. At least three different chronic or acute care services<br><br>4. Patients not recently seen by the practice<br><br>5. Medication monitoring or alert | |
| **PCMH 4: Care Management and Support** | |
| **Element B: Care Planning and Self-Care Support**<br><br>The care team and patient/family/caregiver collaborate (at relevant visits) to develop and update an individual care plan that includes the following features for at least 75 percent of the patients identified in Element A:<br><br>1. Incorporates patient preferences and functional/lifestyle goals<br><br>2. Identifies treatment goals<br><br>3. Assesses and addresses potential barriers to meeting goals<br><br>4. Includes a self-management plan<br><br>5. Is provided in writing to the patient/family/caregiver | Tool 4: Communicate Clearly<br><br>Tool 5: Use the Teach-Back Method<br><br>Tool 6: Follow Up With Patients<br><br>Tool 11: Assess, Select, and Create Easy-to-Understand Materials<br><br>Tool 12: Use Health Education Material Effectively<br><br>Tool 14: Encourage Questions<br><br>Tool 15: Make Action Plans<br><br>Tool 18: Link Patients to Non-Medical Support |

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| | Tool 19: Direct Patients to Medicine Resources<br><br>Tool 20: Connect Patients with Literacy and Math Resources<br><br>Tool 21: Make Referrals Easy |
| **Element C: Medication Management**<br><br>3. Provides information about new prescriptions to more than 80 percent of patients/families/caregivers<br><br>4. Assesses understanding of medications for more than 50 percent of patients/families/caregivers, and dates the assessment<br><br>5. Assesses response to medications and barriers to adherence for more than 50 percent of patients, and dates the assessment<br><br>6. Documents over-the-counter medications, herbal therapies and supplements for more than 50 percent of patients, and dates updates | Tool 4: Communicate Clearly<br><br>Tool 5: Use the Teach-Back Method<br><br>Tool 8: Conduct Brown Bag Medicine Reviews<br><br>Tool 11: Assess, Select, and Create Easy-to-Understand Materials<br><br>Tool 12: Use Health Education Material Effectively<br><br>Tool 14: Encourage Questions<br><br>Tool 16: Help Patients Remember How and When to Take Their Medicine<br><br>Tool 19: Direct Patients to Medicine Resources |
| **Element E: Provide Referrals to Community Resources**<br><br>2. Provides educational materials and resources to patients<br><br>3. Provides self-management tools to record self-care results<br><br>4. Adopts shared decision making aids<br><br>5. Offers or refers patients to structured health education programs, such as group classes and peer support | Tool 4: Communicate Clearly<br><br>Tool 6: Follow Up With Patients<br><br>Tool 11: Assess, Select, and Create Easy-to-Understand Materials<br><br>Tool 12: Use Health Education Material Effectively<br><br>Tool 14: Encourage Questions<br><br>Tool 18: Link Patients to Non-Medical Support |

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| 6. Maintains a current resource list on five topics or key community service areas of importance to the patient population including services offered outside the practice and its affiliates<br><br>7. Assesses usefulness of identified community resources | Tool 19: Direct Patients to Medicine Resources<br><br>Tool 20: Connect Patients with Literacy and Math Resources<br><br>Tool 21: Make Referrals Easy |
| **PCMH 5: Care Coordination and Care Transitions** | |
| **Element A: Test Tracking and Followup**<br><br>1. Tracks lab tests until results are available, flagging and following up on overdue results<br><br>2. Tracks imaging tests until results are available, flagging and following up on overdue results<br><br>5. Notifies patients/families of normal and abnormal lab and imaging test results | Tool 4: Communicate Clearly<br><br>Tool 5: Use the Teach-Back Method<br><br>Tool: 6: Follow Up With Patients<br><br>Tool 11 Assess, Select, and Create Easy-to-Understand Materials<br><br>Tool 14: Encourage Questions<br><br>Tool 21: Make Referrals Easy |

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| **Element B: Referral Tracking and Followup**<br><br>1. Considers available performance information on consultants/specialists when making referral recommendations<br><br>2. Maintains formal and informal agreements with a subset of specialists based on established criteria<br><br>3. Maintains agreements with behavioral healthcare providers<br><br>4. Integrates behavioral healthcare providers within the practice site<br><br>5. Gives the consultant or specialist the clinical question, the required timing and the type of referral<br><br>6. Gives the consultant or specialist pertinent demographic and clinical data, including test results and the current care plan<br><br>7. Has the capacity for electronic exchange of key clinical information+ and provides an electronic summary of care record to another provider for more than 50 percent of referrals<br><br>8. Tracks referrals until the consultant or specialist's report is available, flagging and following up on overdue reports<br><br>9. Documents co-management arrangements in the patient's medical record<br><br>10. Asks patients/families about self-referrals and requesting reports from clinicians | Tool 4: Communicate Clearly<br><br>Tool 6: Follow Up With Patients<br><br>Tool 21: Make Referrals Easy |

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| **Element C: Coordinate Care Transitions**<br><br>4. Proactively contacts patients/families for appropriate followup care within an appropriate period following a hospital admission or emergency department visit | Tool 4: Communicate Clearly<br><br>Tool 5: Use the Teach-Back Method<br><br>Tool: 6: Follow Up With Patients |
| **PCMH 6: Performance Measurement and Quality Improvement** | |
| **Element C: Measure Patient/Family Experience**<br><br>3. The practice obtains feedback on experiences of vulnerable patient groups<br><br>4. The practice obtains feedback from patients/families through qualitative means | Tool 17: Get Patient Feedback (includes CAHPS® Item Set for Addressing Health Literacy and qualitative methods) |
| **Element D: Implement Continuous Quality Improvement**<br><br>5. Set goals and analyze at least one patient experience measure from Element C<br><br>6. Act to improve at least one patient experience measure from Element C<br><br>7. Set goals and address at least one identified disparity in care/service for identified vulnerable populations | Tool 1: Form a Team<br><br>Tool 2: Create a Health Literacy Improvement Plan (Includes PDSA Directions and Example PDSA Worksheets) |

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| **Element E: Demonstrate Continuous Quality Improvement #3**<br><br>1. Measuring the effectiveness of the actions it takes to improve the measures selected in Element D | Tool 2: Create a Health Literacy Improvement Plan (Includes PDSA Directions and Example PDSA Worksheets) |
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| **Joint Commission PCMH Elements of Performance** | **AHRQ Health Literacy Universal Precautions Tool** |
| **LD.04.04.01: Performance Improvement** | |
| EP 5. Ongoing performance improvement occurs organization-wide for the purpose of demonstrably improving the quality and safety of care, treatment or services | Tool 2: Create a Health Literacy Improvement Plan (Includes PDSA Directions and Example PDSA Worksheets) |
| EP 24. Leaders involve patients in performance improvement activities | Tool 1: Form a Team |
| **PC.01.03.01: Plan Patient's Care** | |
| EP 44. Patient self-management goals are identified, agreed upon with the patient, and incorporated into the patient's treatment plan | Tool 4: Communicate Clearly<br><br>Tool 14: Encourage Questions<br><br>Tool 15: Make Action Plans |
| **PC.02.01.21: Effective Communication with Patients** | |

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| EP 1. The primary care clinician and the interdisciplinary team identify the patient's oral and written communication needs, including the patient's preferred language for discussing health care. Note: Examples of communication needs include the need for personal devices such as hearing aids or glasses, language interpreters, communication boards, and translated or plain language materials. | Tool 9: Address Language Differences<br><br>Tool 11: Assess, Select, and Create Easy-to-Understand Materials<br><br>Tool 20: Connect Patients with Literacy and Math Resources (approach patients about literacy issues) |
| EP 2. The primary care clinician and the interdisciplinary team communicate with the patient during the provision of care, treatment, or services in a manner that meets the patient's oral and written communication needs | Tool 4: Communicate Clearly<br><br>Tool 7: Improve Telephone Access<br><br>Tool 9: Address Language Differences<br><br>Tool 11: Assess, Select, and Create Easy-to-Understand Materials<br><br>Tool 14: Encourage Questions |
| **PC.02.02.01: Coordination Based on Patient's Needs** | |
| EP 24. The interdisciplinary team identify the patient's health literacy needs. Note: Typically this is an interactive process. For example, patients may be asked to demonstrate their understanding of information provided by explaining it in their own words | Tool 4: Communicate Clearly<br><br>Tool 5: Use the Teach-Back Method<br><br>Tool 14: Encourage Questions<br><br>Tool 20: Connect Patients with Literacy and Math Resources |
| EP 25. The primary care clinician and the interdisciplinary team incorporate the patient's health literacy needs into the patient's education | Tool 4: Communicate Clearly<br><br>Tool 8: Conduct Brown Bag Medicine Reviews<br><br>Tool 12: Use Health Education Material Effectively |

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| **PC.02.03.01: Patient Education** | |
| EP 28. The primary care clinician and the interdisciplinary team educate the patient on self-management tools and techniques based on the patient's individual needs. | Tool 4: Communicate Clearly<br><br>Tool 5: Use the Teach-Back Method<br><br>Tool: 6: Follow Up With Patients<br><br>Tool 12: Use Health Education Material Effectively<br><br>Tool 14: Encourage Questions<br><br>Tool 15: Make Action Plans<br><br>Tool 16: Help Patients Remember How and When to Take Their Medicine<br><br>Tool 19: Direct Patients to Medicine Resources |
| **PC.02.04.03: Accountability** | |
| EP 1. The organization manages transitions in care and provides or facilitates patient access to care, treatment, or services. | Tool: 6: Follow Up With Patients<br><br>Tool 18: Link Patients to Non-Medical Support<br><br>Tool 20: Connect Patients with Literacy and Math Resources<br><br>Tool 21: Make Referrals Easy |
| **PC.02.04.05: Continuous, Comprehensive, and Coordinate Care** | |

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| EP 2. Members of the interdisciplinary team provide comprehensive and coordinated care, treatment, or services and maintain the continuity of care. Note: The provision of care may include making internal and external referrals | Tool: 6: Follow Up With Patients<br><br>Tool 18: Link Patients to Non-Medical Support<br><br>Tool 20: Connect Patients with Literacy and Math Resources<br><br>Tool 21: Make Referrals Easy |
| EP 6. When a patient is referred to an external organization, the interdisciplinary team reviews and tracks the care provided to the patient | Tool: 6: Follow Up With Patients<br><br>Tool 18: Link Patients to Non-Medical Support<br><br>Tool 20: Connect Patients with Literacy and Math Resources<br><br>Tool 21: Make Referrals Easy |
| EP 13. The interdisciplinary team actively participates in performance improvement activities | Tool 1: Form a Team<br><br>Tool 2: Create a Health Literacy Improvement Plan(Includes PDSA Directions and Example PDSA Worksheets) |
| **PI.01.01.01: Data Collection to Monitor Performance** | |
| EP 42. The organization also collects data on the following: patient experience and satisfaction related to access to care, treatment, or services, and communication | Tool 17: Get Patient Feedback |
| **RC.02.01.01: Clinical Record** | |
| EP 28. The clinical record contains the patient's race and ethnicity. | Tool 10: Consider Culture, Customs, and Beliefs |
| EP 29. The clinical record includes the patient's self-management goals and the patient's progress toward achieving those goals | Tool 15: Make Action Plans |

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| EP 30. The clinical record contains the patient's communication needs, including preferred language for discussing health care | Tool 9: Address Language Differences |
| **RI.01.01.03: Respect Patient's Right to Receive Information in a Manner Her or She Understands** | |
| EP 2. The organization provides interpreting and translation services, as necessary | Tool 9: Address Language Differences<br><br>Tool 11: Assess, Select, and Create Easy-to-Understand Materials |
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| **URAC PCMH Standards** | **AHRQ Health Literacy Universal Precautions Tool** |
| **Core Quality Care Management** | |

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| MH 1: Staff Orientation and Training Requirements Documentation<br>The *Practice* establishes and documents ongoing training programs and initial orientation including the following:<br>a) Approach to *patient engagement* and shared decision-making;<br>b) Team member roles and responsibilities;<br>c) *Patient centered Practice culture* and customer service;<br>d) Current HIPAA requirements as they apply to a covered entity;<br>e) Ethical training that includes prohibition of discrimination;<br>f) Training for specified personnel to use standing orders and/or protocols for wellness and prevention activities;<br>g) Maintenance of *professional competency*; **and**<br>h) Standards of the *Medical Home* that have been implemented. | Tool 1: Form a Team<br><br>Tool 3: Raise Awareness (links to video, PPT, and online training)<br><br>Tool 4: Communicate Clearly<br><br>Tool 5: Use the Teach-Back Method<br><br>Tool 6: Follow Up With Patients<br><br>Tool 9: Address Language Differences<br><br>Tool 10: Culture, Customs, and Beliefs<br><br>Tool 13: Welcome Patients: Helpful Attitude, Signs and More<br><br>Tool 14: Encourage Questions<br><br>Tool 15: Make Action Plans |

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| MH 2: Effective Practice Workflow<br>The *Practice* has a clearly defined organizational structure outlining direct and indirect oversight responsibility throughout the *organization* and identifies a designated facilitator in three (3) areas:<br>a) Teamwork and staff optimization;<br>b) Tracking of *consumer* safety processes, including:<br>i. Adherence to appointments with their *clinician*;<br>ii. Diagnostic and routine testing orders completion and results reporting;<br>iii. Specialty and community services referrals and *Practice* receipt of notification of treatments and/or recommendations;<br>iv. Medication orders followup for *consumer* adherence; **and**<br>v. *Transitions of care* oversight; **and**<br>c) Continuous quality improvement. | Tool 1: Form a Team<br><br>Tool 4: Communicate Clearly<br><br>Tool 6: Follow Up With Patients<br><br>Tool 8: Conduct Brown Bag Medicine Reviews<br><br>Tool 18: Link Patients to Non-Medical Support<br><br>Tool 19:Direct Patients to Medicine Resources<br><br>Tool 20: Connect Patients with Literacy and Math Resources<br><br>Tool 21: Make Referrals Easy |
| MH 3: Patient Empowerment and Engagement<br>The *Practice* ensures that *patients*/*caregivers* are educated and actively engaged in their rights, roles and responsibilities in the shared decision-making process, and are provided with:<br>a) *Consumer* friendly, *culturally/linguistically appropriate*, educational information on their *condition(s)* and health care/*wellness* needs;<br>b) Information about how to be actively engaged in their care; **and**<br>c) Information that helps *patients* increase their awareness of the effect a health care decision may have on their daily lives. | Tool 4: Communicate Clearly<br><br>Tool 5: Use the Teach-Back Method<br><br>Tool 9: Address Language Differences<br><br>Tool 10: Culture, Customs, and Beliefs<br><br>Tool 11: Assess, Select, and Create Easy-to-Understand Materials<br><br>Tool 12: Use Health Education Materials Effectively<br><br>Tool 14: Encourage Questions<br><br>Tool 15: Make Action Plans |

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| MH 4: Health Literacy<br>The *Practice* implements procedures to provide information that is presented in a way that is appropriate to the needs of the *Medical Home patient* population, including:<br>a) Literacy levels; **and**<br>b) Cognitive and/or physical impairments. | Tool 2: Create a Health Literacy Improvement Plan<br><br>Tool 3: Raise Awareness (links to video, PPT, and online training)<br><br>Tool 4: Communicate Clearly<br><br>Tool 5: Use the Teach-Back Method<br><br>Tool 6: Follow Up With Patients<br><br>Tool 7: Improve Telephone Access<br><br>Tool 9: Address Language Differences<br><br>Tool 10: Culture, Customs, and Beliefs<br><br>Tool 11: Assess, Select, and Create Easy-to-Understand Materials<br><br>Tool 12: Use Health Education Materials Effectively<br><br>Tool 13: Welcome Patients: Helpful Attitude, Signs and More<br><br>Tool 14: Encourage Questions<br><br>Tool 15: Make Action Plans<br><br>Tool 16: Help Patients Remember How and When to Take Their Medicines<br><br>Tool 18: Link Patients to Non-Medical Support<br><br>Tool 19: Direct Patients to Medicine Resources<br><br>Tool 20: Connect Patients with Literacy and Math Resources<br><br>Tool 21: Make Referrals Easy |

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| MH 5: Patient Rights and Responsibilities<br><br>Upon enrollment of a *Medical Home patient*, the *Practice* conveys information on rights and responsibilities to *patients* including:<br>a) The right to know about the philosophy and characteristics of the Medical Home Practice and to be treated equitably;<br>b) The right to have personal health information shared within and by the Practice only in accordance with state and federal law;<br>c) The right to be assigned or designate a preferred clinician in the Medical Home Practice;<br>d) The right to receive appropriate current health information from the Practice, including access to diagnostic testing results;<br>e) The right to decline or revoke consent, or dis-enroll at any point in time from the Medical Home;<br>f) The right to provide feedback to the Practice in the form of complaints, satisfaction, or patient experience opportunities;<br>g) The responsibility to actively engage in decisions and make choices regarding their health, wellness and any recommended care or treatment when possible;<br>h) The responsibility to actively participate in recommended care, treatment, or health/wellness/prevention activities;<br>i) The responsibility to submit any necessary forms to the extent required by law, give accurate clinical and contact information and to notify the Practice of changes in this information; and<br>j) The responsibility to notify their other treating clinician(s) of their participation in the Medical Home, if applicable. | Tool 4: Communicate Clearly<br><br>Tool 5: Use the Teach-Back Method<br><br>Tool 11: Assess, Select, and Create Easy-to-Understand Materials<br><br>Tool 14: Encourage Questions |

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| **Patient Centered Operations Management** | |
| MH 6: Patient Registry - Information and Implementation<br>The *Practice* has a *patient* registry that<br>a) Is implemented and includes:<br>i. *Patient* contact information;<br>ii. Demographic information;<br>iii. Care guidelines; **and**<br>iv. Pertinent clinical information; **and**<br>b) Identifies *patients* with:<br>i. High prevalence and/or high-risk *conditions*;<br>ii. Complex *conditions*;<br>iii. *Behavioral health conditions*; **and**<br>iv. Multiple social service needs. | Tool 6: Follow Up With Patients |
| MH 7: Patient Access to Services and Information<br>The *Practice* has a process to ensure that *patients*:<br>a) Have *access* to timely appointments with appropriate *clinician(s)*;<br>b) Have *access* to *referrals* with appropriate specialist(s), if applicable;<br>c) Receive clearly specified hours of office operation and location(s);<br>d) Receive instructions about:<br>i. What to do in an emergency; and<br>ii. How to access after-hour services, as well as non-emergency and urgent care needs; **and**<br>(e) Have *access* to information about wellness and providers providing *preventive services* and their availability. | Tool 7: Improve Telephone Access<br><br>Tool 11: Assess, Select, and Create Easy-to-Understand Materials<br><br>Tool 21: Make Referrals Easy |
| MH 8: Enhancing Patient Access to Services<br>The *Practice* uses the following processes to ensure a higher level of *patient access* and *continuity of care* by including:<br>a) A process for *patient/caregiver* to select a personal | Tool 11: Assess, Select, and Create Easy-to-Understand Materials |

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| *clinician* or team, if applicable;<br>b) Maintaining a record of the *patient/ caregiver's* choice of *clinician*/team in the health record;<br>c) Use of standing orders or protocols for routine medication refills, tests, and/or *wellness*/*preventive services* as applicable;<br>d) Documentation of all clinical advice in the *patient* health records;<br>e) Providing an *electronic* or *written* copy of health information upon request; **and**<br>f) Monitoring proportion of *patient* visits that occur with assigned *clinician*/team. | |
| MH 9: Comprehensive Services and Resources<br>The *Practice* establishes and:<br>a) Provides information to *patients* about community agencies, services, and resources;<br>b) Maintains an updated list of community services and resources; **and**<br>c) Obtains input from *patients* and *Medical Home* team members about community agencies, services, and resources. | Tool 17: Get Patient Feedback<br><br>Tool 18: Link Patients to Non-Medical Support<br><br>Tool 19: Direct Patients to Medicine Resources<br><br>Tool 20: Connect Patients with Literacy and Math Resources |
| MH 10: Community Resource Referrals<br>The *Practice* has implemented a process for patient referrals to community resources such as clinical treatment services beyond the *Practice's* capabilities, as well as other services or agencies, which may include community and social services, mental health, and case management. | Tool 18: Link Patients to Non-Medical Support<br><br>Tool 20: Connect Patients with Literacy and Math Resources<br><br>Tool 21: Make Referrals Easy |
| MH 11: Tracking and Followup on Community Resource Referrals<br>The *Practice* has a process in place to assure:<br>a) *Patients* receive appropriate referrals to community resources; | Tool 5: Use the Teach-Back Method<br><br>Tool 18: Link Patients to Non-Medical Support<br><br>Tool 20: Connect Patients with Literacy and Math Resources |

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| b) Tracking of referrals for high-risk *patients* to community resources;<br>c) *Patients* receive care or services related to the referral;<br>d) The *Practice* receives notification of treatments and/or recommendations provided; **and**<br>e) *Patients* communicate understanding of guidance and recommendations received, as well as the potential benefits from adherence to them. | Tool 21: Make Referrals Easy |
| **Testing and Referrals** | |
| MH 12: Documented Process for Managing Test Results<br>The *Practice* has a documented process in place to manage and track all diagnostic and routine tests and imaging ordered that includes:<br>a) Establishing a time frame for receiving results;<br>b) Flagging overdue results;<br>c) Flagging abnormal and inconclusive results, as well as duplicate results;<br>d) Establishing a time frame for notifying *patients* of results;<br>e) Following up with *patients* regarding abnormal and inconclusive results;<br>f) A mechanism in place for *patients* to receive information for normal results; **and**<br>g) Ensuring all test results are recorded in the health record. | Tool 6: Follow Up With Patients<br><br>Tool 11: Assess, Select, and Create Easy-to-Understand Materials<br><br>Tool 12: Use Health Education Materials Effectively |
| MH 13: Referral Process<br>The *Practice* has an established process to:<br>a) Identify *patients* who need a referral to specialists and/or appropriate clinical programs;<br>b) Coordinate referral appointments;<br>c) Explain the reason(s) for referral to the *patient/caregiver*; | Tool 18: Link Patients to Non-Medical Support<br><br>Tool 21: Make Referrals Easy |

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| **and**<br>d) Involve *patients* in selecting the specialist(s)/*clinician(s)* when appropriate. | |
| MH 14: Tracking and Followup on Clinical Referrals<br>As part of managing its *referrals* to specialists/*clinicians*, the *Practice*:<br>a) Exchanges clinical information with *referral* specialist/*clinician* including the reason for the consultation and pertinent clinical findings;<br>b) Tracks *referrals* and determines if and when the *patient* was seen by the specialist;<br>c) Documents the *referral* dates in the health record;<br>d) Conducts followup to obtain a report from the *referral* specialist/*clinician*; and<br>e) Contacts *patient* for followup if necessary based on a report from the specialist/*clinician.* | Tool 6: Follow Up With Patients<br><br>Tool 21: Make Referrals Easy |
| **Care Management and Coordination** | |
| MH 15: Promoting Wellness and Comprehensive Health Risk Assessment<br>The *Practice* is proactive in promoting *wellness* and preventive care, which includes:<br>a) Use of *health risk assessment tools*;<br>b) Conducting baseline comprehensive health risk *assessment* for all *patients* to help identify health risks and needs as a foundation for establishing an individualized plan of care;<br>c) Assuring all *patients* receive appropriate *wellness* and *preventive care* information about:<br>i. Educational information about risk factors;<br>ii. Personal health lifestyle behaviors; **and**<br>iii. Reducing risk of disease and injury; **and**<br>d) Assuring all *patients* receive appropriate well care visits | Tool 4: Communicate Clearly<br><br>Tool 5: Use the Teach-Back Method<br><br>Tool 6: Follow Up With Patients<br><br>Tool 11: Assess, Select, and Create Easy-to-Understand Materials<br><br>Tool 12: Use Health Education Materials Effectively<br><br>Tool 14: Encourage Questions<br><br>Tool 18: Link Patients to Non-Medical Support |

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| and preventive screenings. | |
| MH 16: Wellness Information and Materials<br>The *Practice* provides information and/or materials about *wellness* and health promotion to its *patients* that:<br>a) Are *evidence-based*;<br>b) Describe the benefits, potential *outcomes*, and interventions associated with the *wellness* activities/services/program;<br>c) Are accessible and available to *patients* through multiple formats; and<br>d) Support *patient* advocacy and empowerment. | Tool 11: Assess, Select, and Create Easy-to-Understand Materials<br><br>Tool 12: Use Health Education Materials Effectively<br><br>Tool 18: Link Patients to Non-Medical Support |
| MH 17: Patient Reminders<br>The *Practice* sends reminders to appropriate *patients*:<br>a) For relevant *preventive care* per *patient* preference;<br>b) Who did not schedule appropriate care within a specified time frame;<br>c) Who were previously contacted by a *Medical Home* team member; and<br>d) For followup care per *patient* preference. | Tool 4: Communicate Clearly<br><br>Tool 6: Follow Up With Patients<br><br>Tool 11: Assess, Select, and Create Easy-to-Understand Materials<br><br>Tool 15: Make Action Plans |
| MH 18: Ongoing Care Management Protocols - All Patients<br>The *Practice* addresses all of the following planning and followup stages of a *patient's* care, including pre-visit, during visit, and between visit followup:<br>a) Conducts pre-visit planning;<br>b) Develops an individualized *care plan* including treatment goals in collaboration with<br>c) *patients* and *caregivers* that addresses a *patient's* comprehensive care needs;<br>d) Incorporates *Practice*-approved *evidence-based* or clinical care guidelines in the *patient's care plan*, as available;<br>e) Reviews *care plan* and assesses progress toward treatment goals at each visit; | Tool 4: Communicate Clearly<br><br>Tool 5: Use the Teach-Back Method<br><br>Tool 6: Follow Up With Patients<br><br>Tool 11: Assess, Select, and Create Easy-to-Understand Materials<br><br>Tool 14: Encourage Questions<br><br>Tool 15: Make Action Plans<br><br>Tool 21: Make Referrals Easy |

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| f) Offers the *patient* a clinical summary (*electronic* or *written*) of the visit and if accepted,<br>g) Provides a copy to the *patient* at each office visit;<br>h) Assesses and arranges or provides treatment for *behavioral health* and substance abuse problems;<br>i) Follows up with *patients* when they have not kept appointments;<br>j) Follows up with *patients* when they have not followed through on *referrals* for diagnostic, therapeutic, or consultative services; and<br>k) Follows up with *patients* between visits as needed based upon identified clinical *condition* and health goals. | |
| MH 19: Informed Decision Making with Patients<br>The *Practice* establishes and implements written policies and documented procedures to promote *patient* decision making, which specify:<br>a) The information the *Practice* will make available to support the clinical decision-making of *patients*;<br>b) The decision support tools and materials it will make available to the *patient*; **and**<br>c) The strategy for engaging *patients* in decisions regarding their care. | Tool 4: Communicate Clearly<br><br>Tool 5: Use the Teach-Back Method<br><br>Tool 11: Assess, Select, and Create Easy-to-Understand Materials<br><br>Tool 12: Use Health Education Materials Effectively<br><br>Tool 14: Encourage Questions |
| MH 20: Medication Review and Reconciliation<br>The *Practice* has implemented a procedure to:<br>a) Perform medication review, by one or more clinicians, at each patient's visit;<br>b) Identify types of patient events that are eligible for medication reconciliation by a clinician at select visits;<br>c) Determine when clinically-equivalent generic substitutions can be recommended giving due consideration to cost and patients' benefits design; and<br>d) Perform medication review and reconciliation for patients when transitions of care occur. | Tool 4: Communicate Clearly<br><br>Tool 5: Use the Teach-Back Method<br><br>Tool 8: Conduct Brown Bag Medicine Reviews<br><br>Tool 14: Encourage Questions<br><br>Tool 16: Help Patients Remember How and When to Take Their Medicines |

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| | Tool 19: Direct Patients to Medicine Resources |
| MH 21: Coordination of Care<br>The *Practice* communicates and coordinates care with a multi-disciplinary team to ensure:<br>a) Ongoing relationships supporting coordinated care;<br>b) Notification between treating providers;<br>c) Followup to emergency department visits; and<br>d) Systematic tracking of care coordination activities. | Tool 21: Make Referrals Easy |
| MH 22: Coordinating Care Transitions and Written Plans<br>The *Practice* has a process in place:<br>a) To ensure that written transition plans are developed, in collaboration with patient and caregiver, where appropriate, for all patients who are transitioning to and from various locations and/or levels of care, starting with the hospital;<br>b) To provide a summary of care record for transition of care or referral;<br>c) To electronically exchange key clinical information; and<br>d) With local health care facilities to help ensure smooth transitions of care for its patients, whereby the processes address the ability to:<br>i. Identify patients with an unplanned hospital admission or emergency department visit;<br>ii. Transmit a patient's clinical information to a hospital or emergency department in a timely fashion;<br>iii. Make contact with patients having unplanned hospital admissions or emergency department visits within reasonable time frames after being notified; and<br>iv. Ensure hospitalizations and emergency department visits are documented in the patient's | Tool 4: Communicate Clearly<br><br>Tool 5: Use the Teach-Back Method<br><br>Tool 11: Assess, Select, and Create Easy-to-Understand Materials<br><br>Tool 14: Encourage Questions<br><br>Tool 21: Make Referrals Easy |

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| health record. | |
| MH 23: Appropriate Use of Clinical Guidelines<br>The *Practice* has written policies and documented procedures in place to assign and implement interventions for clinical conditions based on clinical or evidence-based guidelines, where:<br>a) Rates for provision of services (implementation of guidelines) are tracked and compared to clinical guidelines;<br>b) Practice identifies gaps in patient care and takes appropriate action;<br>c) Practice takes corrective measures, where indicated, to address barriers to care; and<br>d) Practice implements clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule. | Tool 6: Follow Up With Patients<br><br>Tool 18: Link Patients to Non-Medical Support<br><br>Tool 20: Connect Patients with Literacy and Math Resources<br><br>Tool 21: Make Referrals Easy |
| MH 24: Health Record Information Exchange and Alerts<br>The *Practice* has a process to assure that for all *patients* with high prevalence/high risk conditions:<br>1) Alerts of health issues are identified and followup actions initiated;<br>2) Gaps in care are identified triggering *inreach* and outreach activities; **and**<br>3) Medical information is communicated bidirectionally between:<br>i. *Clinicians*, including *referral* sources and, when possible, facility-based *providers*;<br>ii. Pharmacies responsible for dispensing and/or drug therapy oversight; **and**<br>iii. Community-based services and agencies if appropriate. | Tool 6: Follow Up With Patients<br><br>Tool 18: Link Patients to Non-Medical Support<br><br>Tool 20: Connect Patients with Literacy and Math Resources<br><br>Tool 21: Make Referrals Easy |
| MH 25: Chronic Condition - Care Management | Tool 6: Follow Up With Patients |

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| The *Practice* provides individualized care management for patients with chronic conditions by:<br>a) Identifying a minimum of one (1) chronic condition for *Practice* performance improvement consistent with accepted guidelines and decision support rules;<br>b) Monitoring:<br>i. Key clinical data;<br>ii. Clinical outcome measures; and<br>iii. Process measures; and<br>c) Providing feedback to *Practice* clinicians on their performance. | Tool 18: Link Patients to Non-Medical Support<br><br>Tool 20: Connect Patients with Literacy and Math Resources<br><br>Tool 21: Make Referrals Easy |
| MH 26: Self-Management of Chronic Conditions<br>To support *patient* self-management of chronic disease, the *Practice*:<br>a) Offers and provides education and guidance to the *patient*;<br>b) Collaborates with the *patient* to establish self-management goals; **and**<br>c) Monitors *patient* progress toward established self-management goals. | Tool 4: Communicate Clearly<br><br>Tool 5: Use the Teach-Back Method<br><br>Tool 6: Follow Up With Patients<br><br>Tool 11: Assess, Select, and Create Easy-to-Understand Materials<br><br>Tool 12: Use Health Education Materials Effectively<br><br>Tool 14: Encourage Questions<br><br>Tool 15: Make Action Plans<br><br>Tool 16: Help Patients Remember How and When to Take Their Medicines |
| MH 27: Chronic Condition - Appointments<br>The *Practice* has the ability to implement an appointment system for all patients with chronic<br>conditions that:<br>a) Tracks recommended visits to the Practice;<br>b) Tracks appointments with providers; and | Tool 6: Follow Up With Patients<br><br>Tool 11: Assess, Select, and Create Easy-to-Understand Materials |

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| c) Provides appropriate patient notifications and reminders. | |
| MH 28: Chronic Condition - Followup<br>The *Practice* has a process in place to followup with all selected chronic condition patients and provides supportive reinforcement of recommended treatments, tests, referrals, and self-management responsibilities. | Tool 6: Follow Up With Patients |
| MH 29: Self-Management Support and Assessment Capabilities<br>The *Practice* has a process to:<br>a) Assess, document, and monitor a patient/caregiver's capability and confidence in effectively performing self-care responsibilities; and<br>b) Offer support and guidance in establishing and working towards a self-management goal to every patient, including well patients. | Tool 4: Communicate Clearly<br><br>Tool 5: Use the Teach-Back Method<br><br>Tool 6: Follow Up With Patients<br><br>Tool 11: Assess, Select, and Create Easy-to-Understand Materials<br><br>Tool 12: Use Health Education Materials Effectively<br><br>Tool 14: Encourage Questions<br><br>Tool 15: Make Action Plans<br><br>Tool 16: Help Patients Remember How and When to Take Their Medicines |
| **Electronic Capabilities** | |
| MH 31: Basic Electronic Health Record<br>The *Practice's* electronic health record includes the following *patient* information:<br>a) Demographic information;<br>b) Medical history;<br>c) Problem list with current and active diagnoses;<br>d) Active medication list;<br>e) Active medication allergy list;<br>f) Recorded vital signs;<br>g) Viewable clinical lab tests, other tests, and results; | Tool 11: Assess, Select, and Create Easy-to-Understand Materials |

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| h) Documented tobacco use for *patients* 13 years and older; **and**<br>i) Clinical notes. | |
| MH 32: Advanced Electronic Health Record<br>*Electronic Health Record* integrates systems to:<br>a) Order diagnostic tests;<br>b) Request *electronic* prescriptions;<br>c) View digital images of ordered radiology tests;<br>d) Flag abnormal test results;<br>e) Remind *clinicians* of appropriate guidelines and *wellness* screenings;<br>f) Coordinate care;<br>g) Incorporate clinical lab test results as structured data into EHR; **and**<br>h) Identify *patient*-specific educational resources. | Tool 12: Use Health Education Material Effectively |
| MH 33: Electronic Communications Portal<br>The *Practice's electronic* communications portal allows: (No Weight)<br>a) *Clinician* to receive notification of *patient's* self-reported data with indications of potential health risk;<br>b) *Clinician* to send communication to *patients* that includes *wellness* care reminders and *patient* educational information;<br>c) *Patient* and *clinician* to interact via *electronic* visits (e-visits); **and**<br>d) Bidirectional *electronic* communication portal, if included, provides the ability for *patients* to:<br>i. Create a personal health record;<br>ii. View *electronic health records*;<br>iii. Have timely access to electronic health information; **and**<br>iv. View test results, if applicable. | Tool 4: Communicate Clearly<br>Tool 6: Follow Up With Patients<br>Tool 11: Assess, Select, and Create Easy-to-Understand Materials |
| **Quality Performance Reporting and Improvement** | |

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| MH 36: Performance Reporting and Validation<br>The *Practice's* performance reports address and analyze:<br>a) A generated list of *patients* by specific *conditions* to use for quality improvement, reduction of disparities, research, or outreach;<br>b) A process in place to validate its performance data and ensure it accurately reflects the information;<br>c) All *patients* that received *wellness*/*preventive services*;<br>d) All *patients* identified as having a high-risk/high-prevalence chronic condition;<br>e) All *patients* who agreed to participate in the *Medical Home* program;<br>f) Services provided by specialists;<br>g) Services provided by diagnostic testing facilities, hospitals, and other health care *clinicians* or *providers*; **and**<br>h) Ability to *electronically* submit:<br>(i) Ambulatory clinical quality measures selected by CMS;<br>(ii) Data to immunization registries or immunization information systems; **and**<br>(iii) Syndromic surveillance data to public health agencies. | Tool 21: Make Referrals Easy |
| MH 39: Performance Improvement<br>Data analyses are utilized to identify and implement strategies to improve *Practice* performance at the individual and group levels as a part of the *Practice's* continuous quality improvement in the:<br>a) Health of populations;<br>b) Experience of health care; **and**<br>c) Reduction of the costs of health care. | Tool 2: Create a Health Literacy Improvement Plan<br>Tool 17: Get Patient Feedback |